Workplace Sexual Harassment: Potential Long-term Associations with Psychological Function in Older Adults

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INTRODUCTION

Over the past decade, growing public dialogue about workplace sexual harassment has raised questions about the consequences of these experiences on health. Although links between sexual harassment and short-term psychological distress have been reported,^{1, 2} work in this area has largely focused on women, leaving open questions about gender differences in these experiences. Furthermore, research has also focused on working-aged adults, leaving little information about the prevalence and potential lasting impact of harassment in older adults. In this study, we examined associations between workplace sexual harassment exposure and psychological function in a national sample of largely retired older adults.

METHODS

We analyzed data from men and women aged 50 and older in the National Social Life, Health, and Aging Project (Wave 2), a cross-sectional, national probability sample of older community-dwelling adults, with home-based study visits conducted between August 2010 and May 2011 (response rate of 74%).³ The institutional review boards of the University of Chicago and NORC approved the protocol; participants provided informed consent.

Workplace sexual harassment was categorized as a positive response to the self-administered question, “Sometimes at work, men and women find themselves the object of unwanted sexual advances, propositions, or sexual discussions from co-workers or supervisors. The advances sometimes involve physical contact and sometimes just involve sexual conversations. Thinking about your entire life so far, has this ever happened to you?”. Anxiety and depressive symptoms were

identified using a modified Hospital Anxiety and Depression Scale-Anxiety Subscale (score ≥ 8)⁴ and an 11-item Center for Epidemiologic Studies Depression Scale (score ≥ 9).⁵ Sedative-hypnotics and antidepressants were categorized from review of prescribed medications during in-home interviews. Age, race/ethnicity, employment status, and education were self-reported, and body mass index was calculated from height and weight measured by trained study staff.

Descriptive analyses were used to describe and compare key variables. Weighted³ multivariable logistic regression models were used to relate workplace sexual harassment and mood and psychotropic medication use, adjusting for age, race/ethnicity, body mass index, and education. Given known differences in the prevalence of both exposures and outcomes,^{1, 2, 6} all analyses were stratified by gender.

RESULTS

Among 2687 older men and women (mean age 71.50, SE .27), 18% ($n = 224$) of men and close to 30% ($n = 422$) of women endorsed a history of workplace sexual harassment (Table 1). Clinically significant anxiety and depressive symptoms were observed in 19.0% and 16.2% of men and 21.5% and 20.4% of women, respectively; 9.1% of men and 15.1% of women used sedative-hypnotics, and 10.7% of men and 18.3% of women used antidepressants. In adjusted analyses, no significant associations between sexual harassment and psychological function outcomes were detected among men. Women endorsing sexual harassment had higher odds of current depressive symptoms, anxiety, and sedative-hypnotic use (Table 2).

DISCUSSION

In this national sample of adults aged 50 and older, close to 1 in 5 men and 1 in 3 women reported lifetime workplace sexual harassment exposure. Furthermore, women reporting harassment were more likely to have clinically significant anxiety and depressive symptoms and to use sedative-hypnotics in older age. While the cross-sectional design of this study limits our ability to assess causality, these findings raise concerns about potential long-term psychological consequences of these common experiences and effects on high-risk medication use in older age, at least for older women.

Prior Presentations

These findings have not been previously presented at any national or regional conferences, nor published elsewhere.

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Table 1 Baseline Characteristics of Study Participants (n = 2687)

	Women (n = 1494)	Men (n = 1193)
Characteristic	n (weighted %)	n (weighted %)
Age (weighted mean, SE)	71.06 (.26)	71.80 (.31)
Body mass index (weighted mean, SE)	32.54 (3.28)	29.59 (.22)
Race/ethnicity		
Non-Latina White	1101 (82.8)	910 (84.92)
Black or African American	201 (8.0)	121 (5.54)
Latina or Hispanic	149 (6.2)	131 (6.96)
Other	36 (2.6)	28 (2.59)
Education		
<High school	244 (13.7)	213 (14.12)
High school/GED	388 (26.2)	268 (21.71)
Some college	538 (38.5)	340 (28.72)
College or more	324 (21.6)	372 (35.44)

Missing values: age 0, race/ethnicity 7, education 0, BMI 66

This study provides new national data on workplace sexual harassment among older adults, addressing the paucity of research in this area. Similar associations between workplace

sexual harassment and mental health in women, but not men, have been previously reported in samples of reproductive-aged adults,¹ though not seen in a prior study of midlife women.² Potential explanations for these differences include gender differences in the perception and appraisal of harassment experiences.^{1, 2} Limitations of the current study include an inability to determine the severity and chronicity of harassment experiences, as well as elapsed time since exposure. Additionally, clinical depression and anxiety diagnoses, as well as the duration and indication of medication use, cannot be determined from these data. Nevertheless, these findings highlight high lifetime prevalence of harassment exposure in older adults with potential links to late-life psychological function among older women, underscoring the need for research to investigate long-term consequences of sexual harassment across the lifespan.

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Table 2 Associations Between Mood Symptoms, Psychotropic Medication Use, and History of Workplace Sexual Harassment

	Workplace sexual harassment	No workplace sexual harassment	OR (95% CI)
Women	(n = 422, 29.7%)	(n = 1072, 70.3%)	
Anxiety ^a	118 (27.2)	203 (18.3)	1.7 (1.1–2.6)
Depressive symptoms ^b	102 (24.4)	203 (18.0)	1.9 (1.4–2.7)
Sedative-hypnotic use ^c	81 (17.9)	144 (14.3)	1.5 (1.1–2.1)
Antidepressant use ^d	90 (22.3)	184 (18.6)	1.2 (0.9–1.7)
Men	(n = 224, 18.6%)	(n = 969, 81.4%)	
Anxiety ^a	54 (20.8)	184 (18.6)	1.2 (0.8–1.8)
Depressive symptoms ^b	38 (13.1)	168 (17.0)	0.8 (0.5–1.2)
Sedative-hypnotic use ^c	23 (8.7)	78 (9.1)	1.0 (0.6–1.9)
Antidepressant use ^d	28 (11.5)	103 (10.5)	1.0 (0.5–1.9)

Full information maximum likelihood models, adjusted for age, race/ethnicity, BMI, and education. Weighted percents shown for all values. Note: Anxiety and depressive symptoms were slightly attenuated but still significant in women with further adjustment for antidepressant use and sedative-hypnotic use

^aHADS-A ≥ 8

^bShort form CES-D ≥ 9

^cIncludes barbiturates; benzodiazepines; and miscellaneous anxiolytics, sedatives, and hypnotics based on review of prescribed medications

^dIncludes SSRIs, SSRIs, miscellaneous antidepressants, monoamine oxidase inhibitors, phenylpiperazine antidepressants, tetracyclic antidepressants, and tricyclic antidepressants based on review of prescribed medications

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Compliance with Ethical Standards:

Conflict of Interest: The authors have no other conflicts of interest to report.

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